PHYSICIANS GROUP
SERVICES

ACKNOWLEDGEMENT OF PRIVACY NOTICE

PATIENT:

I certify that I received a copy of the Notice of Privacy Practices and I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information.

Patient Signature:			
Printed Patient Name:			
Date:		Patient Date of Birth:	

AUTHORIZED PATIENT REPRESENTATIVE:

I certify that I am the authorized representative of _____ and I have received the Notice of Privacy Practices on behalf of this individual. The provider provided me with an opportunity to review this document and ask questions to assist me in understanding his/her rights relative to the protection of his/her health information.

Representative Signature:	
Printed Representative Name:	
Printed Patient Name:	
Relationship to Patient:	
Date:	

FOR OFFICE USE ONLY:

Patient/Representative refused to sign Acknowledgement of Privacy Notice.

Office Personnel Printed Name:			
Date		Patient Acct. #:	

A copy of this document must be provided to the person to whom the Privacy Notice was provided and a copy must be filed in the patient's medical record.